

1613 CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b 3 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert Co., Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Susan Middle Bigham Last Bigham				4. DATE OF DEATH Month 2 Day 26 Year 19 57			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-27-1869		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Adams Co., Penn.	
13. FATHER'S NAME Adam Eylor				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. None		17. INFORMANT Charles Bigham (Son) North Beach Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral accident DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs 3 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 1956 , to 1957 , that I last saw the deceased alive on 19 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2/26/57							
ACTUAL SIGNATURE H W Ward				M.D. 2/26/57			
PHYSICIAN'S NAME (Type) Dr. H.W. Ward							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/1957		22c. NAME OF CEMETERY OR CREMATORY Fairfield Union		22d. LOCATION (City, town, or county) (State) Fairfield, Adams Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE S. L. Allison				ADDRESS Fairfield, Pa.		24a. REC'D BY REGISTRAR MAR 1 1957	
				24b. REGISTRAR'S SIGNATURE S. L. Allison			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

255

1 MAR 1 1957

RECEIVED

1614 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u></u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u></u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Ann Bowen</u>				4. DATE OF DEATH Month <u>2</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 26 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Thos Sheddell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gibson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>Mr R. Ward, Huntingtown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month. <u></u> Day. <u>19</u> Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Feb 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 1</u> , 19 <u>57</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. W. Ward</u>				ADDRESS (Street, city or town, state) <u>Owings, Md</u>			
PHYSICIAN'S NAME (Type) <u>H. W. WARD</u>				DATE SIGNED <u>2/1/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Huntingtown Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingtown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. A. Warkness & Son - Mutual, Md</u>				24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	
DATE <u>2-4-57</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

1957 5 FEB

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01625

1615

CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY in 1b 22days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First J. Middle Frank Last Brady			4. DATE OF DEATH Month February Day 3 Year 1957				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 24, 1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Month 8 Days 3 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter Brady		14. MOTHER'S MAIDEN NAME Mary Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 720		17. INFORMANT Harvey Brady		Address Prince Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Nov , 1956, to 2/2 , 1957, that I last saw the deceased alive on 2/2 , 1957, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE George J. Weems				ADDRESS (Street, city or town, state) DATE SIGNED 7 Washington Road 2/2/57			
PHYSICIAN'S NAME (Type) Dr. George J. Weems							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 5, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Ceme		22d. LOCATION (City, town, or county) (State) Prince Frederick, Md	
23. FUNERAL DIRECTOR'S SIGNATURE O. Q. Harkness & Son				24a. REC'D BY REGISTRAR DATE 2-5-57		24b. REGISTRAR'S SIGNATURE N. W. Ward	

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only one day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
01626											
Reg. Dist. No. 51											
1. PLACE OF DEATH a. COUNTY CALVERT MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY Calvert						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JEWELL					c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) JEWELL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DORSEY Middle BROOKS JR. Last BROOKS JR.					4. DATE OF DEATH Month FEBRUARY Day 28 Year 19 57						
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/22/55		9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY MARYLAND					12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DORSEY BROOKS, SR.					14. MOTHER'S MAIDEN NAME ADELAIDE JONES						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT DORSEY BROOKS		Address JEWELL, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 962X Subdural Hydroma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO DUE TO										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Trauma to head during delivery						
20c. TIME OF INJURY Month, Day, Year Hour Unknown o. Unknown p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Unknown		20f. (City or town) (County) (State) Unknown		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
22a. BURIAL, CREMATION, REMOVAL (Specify) bur. 3. 57					22b. DATE THEREOF Mar. 3. 57		22c. NAME OF CEMETERY OR CREMATORY St. Edmunds		22d. LOCATION (City, town, or county) (State) St. Edmunds Md		
23. FUNERAL DIRECTOR'S SIGNATURE P. J. Sewell, Jr.					ADDRESS P.O. Frederick, Md		24a. REC'D BY REGISTRAR DATE 3-1-57		24b. REGISTRAR'S SIGNATURE H. W. Ward		
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>					EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2/28/57		

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BR

NAME: JEWELL
RESIDENCE: JEWELL
OCCUPATION: JEWELL
DATE OF BIRTH: JEWELL
PLACE OF BIRTH: JEWELL

DATE OF DEATH: JEWELL
PLACE OF DEATH: JEWELL
CAUSE OF DEATH: JEWELL
MANNER OF DEATH: JEWELL
SEX: JEWELL
AGE: JEWELL
U.S.A. JEWELL
JEWELL, MD. JEWELL
JEWELL, MD. JEWELL

RECEIVED
MAR 5 1937
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1617 CERTIFICATE OF DEATH

01627

Reg. Dist. No. 51

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Brooks</u> Last <u>Brooks</u>			4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>19 57</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>56</u> yrs.		9. AGE (In years last birthday) <u>56</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Alexander Brooks</u>			14. MOTHER'S MAIDEN NAME <u>Zora Fowler</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Martell Brooks</u> Address <u>Huntingtown, md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis -</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension c.v.d.</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1/9</u> , 19 <u>57</u> , to <u>2/20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/20</u> , 19 <u>57</u> , and that death occurred at <u>12:30 P.</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Roberto De Villarreal</u> M.D.		ADDRESS (Street, city or town, state) <u>St. Remond, Md.</u> DATE SIGNED <u>2/20</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Roberto De Villarreal</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 24-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Patuxent</u>	
22d. LOCATION (City, town, or county) <u>Huntingtown</u>		22e. (State) <u>md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. J. Sewell</u>		ADDRESS <u>Pr. Fred. md</u>		24a. REC'D BY REGISTRAR DATE <u>2-21-57</u>	
24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>					

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>	
<p>4. PLACE OF BIRTH</p>		<p>5. OCCUPATION</p>		<p>6. CAUSE OF DEATH</p>	
<p>7. DATE OF DEATH</p>		<p>8. TIME OF DEATH</p>		<p>9. PLACE OF DEATH</p>	
<p>10. SIGNATURE OF DECEASED</p>		<p>11. SIGNATURE OF WITNESS</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF DECEASED</p>		<p>14. SIGNATURE OF WITNESS</p>		<p>15. SIGNATURE OF DECEASED</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF WITNESS</p>		<p>18. SIGNATURE OF DECEASED</p>	
<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF WITNESS</p>		<p>21. SIGNATURE OF DECEASED</p>	
<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF WITNESS</p>		<p>24. SIGNATURE OF DECEASED</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF WITNESS</p>		<p>27. SIGNATURE OF DECEASED</p>	
<p>28. SIGNATURE OF DECEASED</p>		<p>29. SIGNATURE OF WITNESS</p>		<p>30. SIGNATURE OF DECEASED</p>	
<p>31. SIGNATURE OF DECEASED</p>		<p>32. SIGNATURE OF WITNESS</p>		<p>33. SIGNATURE OF DECEASED</p>	
<p>34. SIGNATURE OF DECEASED</p>		<p>35. SIGNATURE OF WITNESS</p>		<p>36. SIGNATURE OF DECEASED</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF WITNESS</p>		<p>39. SIGNATURE OF DECEASED</p>	
<p>40. SIGNATURE OF DECEASED</p>		<p>41. SIGNATURE OF WITNESS</p>		<p>42. SIGNATURE OF DECEASED</p>	
<p>43. SIGNATURE OF DECEASED</p>		<p>44. SIGNATURE OF WITNESS</p>		<p>45. SIGNATURE OF DECEASED</p>	
<p>46. SIGNATURE OF DECEASED</p>		<p>47. SIGNATURE OF WITNESS</p>		<p>48. SIGNATURE OF DECEASED</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF WITNESS</p>		<p>51. SIGNATURE OF DECEASED</p>	
<p>52. SIGNATURE OF DECEASED</p>		<p>53. SIGNATURE OF WITNESS</p>		<p>54. SIGNATURE OF DECEASED</p>	
<p>55. SIGNATURE OF DECEASED</p>		<p>56. SIGNATURE OF WITNESS</p>		<p>57. SIGNATURE OF DECEASED</p>	
<p>58. SIGNATURE OF DECEASED</p>		<p>59. SIGNATURE OF WITNESS</p>		<p>60. SIGNATURE OF DECEASED</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF WITNESS</p>		<p>63. SIGNATURE OF DECEASED</p>	
<p>64. SIGNATURE OF DECEASED</p>		<p>65. SIGNATURE OF WITNESS</p>		<p>66. SIGNATURE OF DECEASED</p>	
<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF WITNESS</p>		<p>69. SIGNATURE OF DECEASED</p>	
<p>70. SIGNATURE OF DECEASED</p>		<p>71. SIGNATURE OF WITNESS</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF WITNESS</p>		<p>75. SIGNATURE OF DECEASED</p>	
<p>76. SIGNATURE OF DECEASED</p>		<p>77. SIGNATURE OF WITNESS</p>		<p>78. SIGNATURE OF DECEASED</p>	
<p>79. SIGNATURE OF DECEASED</p>		<p>80. SIGNATURE OF WITNESS</p>		<p>81. SIGNATURE OF DECEASED</p>	
<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF WITNESS</p>		<p>84. SIGNATURE OF DECEASED</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF WITNESS</p>		<p>87. SIGNATURE OF DECEASED</p>	
<p>88. SIGNATURE OF DECEASED</p>		<p>89. SIGNATURE OF WITNESS</p>		<p>90. SIGNATURE OF DECEASED</p>	
<p>91. SIGNATURE OF DECEASED</p>		<p>92. SIGNATURE OF WITNESS</p>		<p>93. SIGNATURE OF DECEASED</p>	
<p>94. SIGNATURE OF DECEASED</p>		<p>95. SIGNATURE OF WITNESS</p>		<p>96. SIGNATURE OF DECEASED</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF WITNESS</p>		<p>99. SIGNATURE OF DECEASED</p>	
<p>100. SIGNATURE OF DECEASED</p>		<p>101. SIGNATURE OF WITNESS</p>		<p>102. SIGNATURE OF DECEASED</p>	

BUREAU V. S.

FEB 26 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

1618

Item 8, Film G211, 3/8/57 bh
CERTIFICATE OF DEATH

01628

Reg. Dist. No. 51

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Swings</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eurbia</u> <u>Curtiss</u>				4. DATE OF DEATH Month Day Year <u>2</u> <u>26</u> <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Major Curtiss</u>				14. MOTHER'S MAIDEN NAME <u>Carolina ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Savonia Jacks - Swings, md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>Chemia - hepatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Cerebral-Delemon</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/25</u> , 19 <u>57</u> , to <u>2/26</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/26</u> , 19 <u>57</u> , and that death occurred at <u>2:00</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert De Villarreal</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Dr. Roberto De Villarreal</u>							
22a. BURIAL/CREMATION, REMOVAL (Specify) <u>3-1-57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Sundusud Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sawell, Pr. Fred, Md</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>3-1-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

REG. NO. 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE		22. SIGNATURE OF JAILER		23. SIGNATURE OF PRISONER		24. SIGNATURE OF WARDEN		25. SIGNATURE OF CHIEF OF POLICE		26. SIGNATURE OF DEPUTY CHIEF OF POLICE		27. SIGNATURE OF SQUAD LEADER		28. SIGNATURE OF OFFICER		29. SIGNATURE OF SERGEANT		30. SIGNATURE OF PATROLMAN		31. SIGNATURE OF DETECTIVE		32. SIGNATURE OF INSPECTOR		33. SIGNATURE OF SUPERVISOR		34. SIGNATURE OF COMMANDER		35. SIGNATURE OF CHIEF OF FIRE DEPARTMENT		36. SIGNATURE OF DEPUTY CHIEF OF FIRE DEPARTMENT		37. SIGNATURE OF ENGINEER		38. SIGNATURE OF DRIVER		39. SIGNATURE OF MECHANIC		40. SIGNATURE OF ELECTRICIAN		41. SIGNATURE OF PLUMBER		42. SIGNATURE OF CARPENTER		43. SIGNATURE OF PAINTER		44. SIGNATURE OF ROOFER		45. SIGNATURE OF GARDENER		46. SIGNATURE OF FLOWER SELLER		47. SIGNATURE OF VENDOR		48. SIGNATURE OF STREET CLEANER		49. SIGNATURE OF SANITARY ENGINEER		50. SIGNATURE OF PUBLIC WORKS ENGINEER		51. SIGNATURE OF INSPECTOR OF BUILDINGS		52. SIGNATURE OF INSPECTOR OF FIRE ALARMS		53. SIGNATURE OF INSPECTOR OF ELEVATORS		54. SIGNATURE OF INSPECTOR OF STREETS		55. SIGNATURE OF INSPECTOR OF TRAILS		56. SIGNATURE OF INSPECTOR OF BRIDGES		57. SIGNATURE OF INSPECTOR OF DOCKS		58. SIGNATURE OF INSPECTOR OF WHARVES		59. SIGNATURE OF INSPECTOR OF SHIPS		60. SIGNATURE OF INSPECTOR OF AIRCRAFT		61. SIGNATURE OF INSPECTOR OF RAILROADS		62. SIGNATURE OF INSPECTOR OF TROLLEYS		63. SIGNATURE OF INSPECTOR OF CARS		64. SIGNATURE OF INSPECTOR OF BUSES		65. SIGNATURE OF INSPECTOR OF TRUCKS		66. SIGNATURE OF INSPECTOR OF MOTORCYCLES		67. SIGNATURE OF INSPECTOR OF BOATS		68. SIGNATURE OF INSPECTOR OF YACHTS		69. SIGNATURE OF INSPECTOR OF FISH BOATS		70. SIGNATURE OF INSPECTOR OF CRUISE SHIPS		71. SIGNATURE OF INSPECTOR OF TUGS		72. SIGNATURE OF INSPECTOR OF BARGE		73. SIGNATURE OF INSPECTOR OF TUGS		74. SIGNATURE OF INSPECTOR OF BARGE		75. SIGNATURE OF INSPECTOR OF TUGS		76. SIGNATURE OF INSPECTOR OF BARGE		77. SIGNATURE OF INSPECTOR OF TUGS		78. SIGNATURE OF INSPECTOR OF BARGE		79. SIGNATURE OF INSPECTOR OF TUGS		80. SIGNATURE OF INSPECTOR OF BARGE		81. SIGNATURE OF INSPECTOR OF TUGS		82. SIGNATURE OF INSPECTOR OF BARGE		83. SIGNATURE OF INSPECTOR OF TUGS		84. SIGNATURE OF INSPECTOR OF BARGE		85. SIGNATURE OF INSPECTOR OF TUGS		86. SIGNATURE OF INSPECTOR OF BARGE		87. SIGNATURE OF INSPECTOR OF TUGS		88. SIGNATURE OF INSPECTOR OF BARGE		89. SIGNATURE OF INSPECTOR OF TUGS		90. SIGNATURE OF INSPECTOR OF BARGE		91. SIGNATURE OF INSPECTOR OF TUGS		92. SIGNATURE OF INSPECTOR OF BARGE		93. SIGNATURE OF INSPECTOR OF TUGS		94. SIGNATURE OF INSPECTOR OF BARGE		95. SIGNATURE OF INSPECTOR OF TUGS		96. SIGNATURE OF INSPECTOR OF BARGE		97. SIGNATURE OF INSPECTOR OF TUGS		98. SIGNATURE OF INSPECTOR OF BARGE		99. SIGNATURE OF INSPECTOR OF TUGS		100. SIGNATURE OF INSPECTOR OF BARGE	
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RECEIVED
MAR 5 1937
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01629

1619 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>Cabnet</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabnet</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Broomes Island</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Broomes Island</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>—</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN W. DENTON</u>				4. DATE OF DEATH Month Day Year <u>Feb 28 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1865</u>	9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>0 25</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>		11. BIRTHPLACE (State or foreign country) <u>Cabnet Co., Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Virgil Denton</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>Warren Denton - Broomes Island, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 26</u> , 19 <u>57</u> , to <u>Feb 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 28</u> , 19 <u>57</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2/1/57</u> ACTUAL SIGNATURE <u>Page C. Jett</u> M.D. <u>Prince Frederick</u> PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u> <u>PRINCE FREDERICK MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Port Republic - Cabnet Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Hackness & Son - Mutual, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3-1-57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18 CERTIFICATE OF DEATH

BUREAU V. S.

MAR 5 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01630

Reg. Dist. No. 51

1620

1. PLACE OF DEATH a. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach, Md		c. LENGTH OF STAY IN TB XO	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First THOMAS Middle Last FOSTER		4. DATE OF DEATH Found February 17 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH P
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY md	
11. BIRTHPLACE (State or foreign country) md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Forrester		14. MOTHER'S MAIDEN NAME Sarah Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Annie Jones, West Beach, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive heart disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 322.0 Acute alcoholism			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Feb. 20, 57	
22c. NAME OF CEMETERY OR CREMATORY St. Edmonds		22d. LOCATION (City, town, or county) (State) Calvert Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell, P. E. Fred, Md.		24a. REC'D BY REGISTRAR DATE 2-19-57	
		24b. REGISTRAR'S SIGNATURE A. W. Ward	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the file of the deceased. Page 5 may be retained for the file of the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THESE ARE THE

DEATH

RECORD

DATE

TIME

PLACE

CAUSE OF DEATH

SEX

AGE

RACE

EDUCATION

BUREAU V. S.

FEB 20 1957

RECEIVED

1
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64
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1
4
VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01631

1621

CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY MARYLAND Calvert County Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lusby					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
c. LENGTH OF STAY IN 1b 5 Days				d. STREET ADDRESS Lusby					
d. NAME OF HOSPITAL (If not in hospital, give street address) Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Edna First Graham Middle Graham Last				4. DATE OF DEATH 2 Month 21 Day 57 Year 19					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1956			
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) Maryland U.S.A.					
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Joseph Graham				14. MOTHER'S MAIDEN NAME Violet Gross					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mother		Address Lusby, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) malnutrition 772.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 772.0								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 2-16 , 19 57 , to 2-21 , 19 57 , that I lost saw the deceased alive on Feb 21 , 19 57 , and that death occurred at 3:45 M, from the causes and on the date stated above.									
ACTUAL SIGNATURE Dr. Roberto Villarreal				DATE SIGNED 2/21					
PHYSICIAN'S NAME (Type)									
22a. (BURIAL) CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Feb 23 1957		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Lusby Md			
23. FUNERAL DIRECTOR'S SIGNATURE P. E. Sewell				ADDRESS Prince Frederick		24a. REC'D BY REGISTRAR H. W. Ward			
24b. REGISTRAR'S SIGNATURE									

2064309XY5

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. NAME OF PHYSICIAN		13. NAME OF FUNERAL HOME		14. NAME OF BURIAL PLACE		15. NAME OF MINISTER	
16. NAME OF WITNESS		17. NAME OF WITNESS		18. NAME OF WITNESS		19. NAME OF WITNESS		20. NAME OF WITNESS	
21. NAME OF WITNESS		22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS		25. NAME OF WITNESS	
26. NAME OF WITNESS		27. NAME OF WITNESS		28. NAME OF WITNESS		29. NAME OF WITNESS		30. NAME OF WITNESS	
31. NAME OF WITNESS		32. NAME OF WITNESS		33. NAME OF WITNESS		34. NAME OF WITNESS		35. NAME OF WITNESS	
36. NAME OF WITNESS		37. NAME OF WITNESS		38. NAME OF WITNESS		39. NAME OF WITNESS		40. NAME OF WITNESS	
41. NAME OF WITNESS		42. NAME OF WITNESS		43. NAME OF WITNESS		44. NAME OF WITNESS		45. NAME OF WITNESS	
46. NAME OF WITNESS		47. NAME OF WITNESS		48. NAME OF WITNESS		49. NAME OF WITNESS		50. NAME OF WITNESS	
51. NAME OF WITNESS		52. NAME OF WITNESS		53. NAME OF WITNESS		54. NAME OF WITNESS		55. NAME OF WITNESS	
56. NAME OF WITNESS		57. NAME OF WITNESS		58. NAME OF WITNESS		59. NAME OF WITNESS		60. NAME OF WITNESS	
61. NAME OF WITNESS		62. NAME OF WITNESS		63. NAME OF WITNESS		64. NAME OF WITNESS		65. NAME OF WITNESS	
66. NAME OF WITNESS		67. NAME OF WITNESS		68. NAME OF WITNESS		69. NAME OF WITNESS		70. NAME OF WITNESS	
71. NAME OF WITNESS		72. NAME OF WITNESS		73. NAME OF WITNESS		74. NAME OF WITNESS		75. NAME OF WITNESS	
76. NAME OF WITNESS		77. NAME OF WITNESS		78. NAME OF WITNESS		79. NAME OF WITNESS		80. NAME OF WITNESS	
81. NAME OF WITNESS		82. NAME OF WITNESS		83. NAME OF WITNESS		84. NAME OF WITNESS		85. NAME OF WITNESS	
86. NAME OF WITNESS		87. NAME OF WITNESS		88. NAME OF WITNESS		89. NAME OF WITNESS		90. NAME OF WITNESS	
91. NAME OF WITNESS		92. NAME OF WITNESS		93. NAME OF WITNESS		94. NAME OF WITNESS		95. NAME OF WITNESS	
96. NAME OF WITNESS		97. NAME OF WITNESS		98. NAME OF WITNESS		99. NAME OF WITNESS		100. NAME OF WITNESS	

BUREAU V. 3

FEB 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01632

1622

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <u>CALVERT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CALVERT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCE FREDERICK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BARSTOW</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CALVERT COUNTY HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ZACH</u> <u>B.</u> <u>GRAY</u>				4. DATE OF DEATH Month Day Year <u>FEB.</u> <u>2</u> , <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 13, 1880</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>10</u> <u>19</u>	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>CALVERT CO. - MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN M. GRAY</u>				14. MOTHER'S MAIDEN NAME <u>MARCISSUS BOWEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>MRS LILLIAN GRAY - BARSTOW - MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ca. of lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 2</u> , 19 <u>57</u> , to <u>Feb 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Feb 2</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R de Villarreal</u> M.D.				ADDRESS (Street, city or town, state) <u>St Remond, no 3457</u>			
PHYSICIAN'S NAME (Type) <u>R de VILLARREAL</u>				DATE SIGNED <u>MD 2/4/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CENTRAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BARSTOW - CALVERT CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.A. HARKNESS & SON - MUTUAL, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>2/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, DEC. 18

FILE NO. 12

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. COLOR [Faint text]		9. RELIGION [Faint text]		10. EDUCATION [Faint text]		11. SOCIAL SECURITY NO. [Faint text]		12. MANNER OF DEATH [Faint text]	
13. CAUSE OF DEATH [Faint text]		14. PLACE OF DEATH [Faint text]		15. TIME OF DEATH [Faint text]		16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF PHYSICIAN [Faint text]	
19. SIGNATURE OF REGISTRAR [Faint text]		20. SIGNATURE OF CLERK [Faint text]		21. SIGNATURE OF CHIEF CLERK [Faint text]		22. SIGNATURE OF ASSISTANT CLERK [Faint text]		23. SIGNATURE OF DEPUTY CLERK [Faint text]		24. SIGNATURE OF DEPUTY ASSISTANT CLERK [Faint text]	

BUREAU V. 2

FEB 5 1957

RECEIVED

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, DEC. 18

1623

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY Calvert County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alexander Middle Last Gross				4. DATE OF DEATH Month 2 Day 4 Year 1957			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-12-85	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster shicker				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Gross				14. MOTHER'S MAIDEN NAME Dusie Ragland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Pinkney Sewell, Prince Frederick, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Benign prostatic hypertrophy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-14 , 19 57 , to 2-4 , 19 57 , that I last saw the deceased alive on 4-12 , 19 57 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 54 Remond DATE SIGNED ACTUAL SIGNATURE R DeVillars M.D. PHYSICIAN'S NAME (Type) R DeVillars							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
2-7-57		St Johns		husby		md	
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell				ADDRESS Prince Fred.		24a. REC'D BY REGISTRAR DATE 2-7-57	
						24b. REGISTRAR'S SIGNATURE H. W. Ward	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
John J. Jones		Male		45		1912		Baltimore		Maryland		United States		United States	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Salesman		Heart Disease		Natural		1957		Baltimore		Maryland		United States		United States	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY		STATE		COUNTRY	
None		None		None		1957		Baltimore		Maryland		United States		United States	
SIGNATURE OF PHYSICIAN		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY	
1957		Baltimore		Maryland		United States		United States		1957		Baltimore		Maryland	

BUREAU V. S.

FEB 11 1957

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 51

1624

1. PLACE OF DEATH o. COUNTY <u>Calvert</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Calvert</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Republic</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co. H</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Harold</u> Last <u>Harold</u>			4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1906</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>Cornelius Harold</u>			14. MOTHER'S MAIDEN NAME <u>Julia Keller</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-01-2684</u>		17. INFORMANT <u>John Harold J. St. Leonards</u> Address <u>St. Leonards</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dropped dead in P.T. while talking</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>10:21</u> <u>2/9</u> <u>1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>P.T.</u>		20f. (City or town) <u>Calvert</u>	(County) <u>Md</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/9/57</u>	
EXAMINER'S NAME (Type) <u>H. W. Ward</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-11-57</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Browns</u>	22d. LOCATION (City, town, or county) (State) <u>Port Republic Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell, Prince Fred</u>			24a. REC'D BY REGISTRAR DATE <u>2-11-57</u>		24b. REGISTRAR'S SIGNATURE <u>H. W. Ward</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the use of the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
FEB 13 1957
BUREAU V. S.

RECEIVED
FEB 13 1957
BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

01635

1625

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>pr yeo's Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>34 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Elgar</u> Middle <u>C</u> Last <u>Mead</u>				4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18 - 1896</u>	9. AGE (In years last birthday) <u>60</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Liquor Dealer</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Liquor Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Liquor Dealer</u>		10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		10d. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph E. Mead</u>				14. MOTHER'S MAIDEN NAME <u>Rose E. Howard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Mrs. Alice Mead - 203 Black Hawk Dr. S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u>						INTERVAL BETWEEN ONSET AND DEATH <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
20f. (City or town) <u>---</u>				20g. (County) <u>---</u>		20h. (State) <u>---</u>	
21. I certify that I attended the deceased from <u>1/16</u> , 19 <u>57</u> , to <u>2/19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>2/19</u> , 19 <u>57</u> , and that death occurred at <u>1:45 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. E. KILLGORE</u> M.D.				DATE SIGNED <u>2/19/57</u>			
PHYSICIAN'S NAME (Type) <u>R. E. KILLGORE, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 22 - 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Summerville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summerville Bros. 1661 - Good Hope Rd</u>				ADDRESS <u>Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>---</u>	
				24b. REGISTRAR'S SIGNATURE <u>Hugh Hinds</u>		DATE <u>FEB 21 1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. 5

FEB 21 1957

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